H1N1 Vaccine Administrative Record (College Students)

IMPORTANT!! PLEASE NOTE:

- IF YOU HAVE **GUILLAIN-BARRE SYNDROME** OR ARE **ALLERGIC TO EGGS**, YOU ARE **NOT** ELIGIBLE FOR THIS PROGRAM. *PLEASE DO NOT RETURN THIS FORM!*
- IF YOU HAVE **GUILLAIN-BARRE SYNDROME** OR ARE **ALLERGIC TO EGGS**, PLEASE CONTACT YOUR MEDICAL PROVIDER TO DETERMINE YOUR ELIGIBILITY TO RECEIVE H1N1 VACCINE ELSEWHERE, WHEN AVAILABLE.

Patient's Name: (Last, First, MI)	*Date of Birth:* __ __/__ __/__ __ __ __	☐*Male* ☐*Female*	*Patient's Phone:*
☐ I **do not** have Blue Cross/Blue Shield of RI or UnitedHealthcare health insurance. I will not be charged for this vaccination.			*E-Mail Address:*

Insurance Information

Patient's Address:	*City, State & Zip Code*	*Relation to Policy Holder:* ☐*Self* ☐*Child* ☐*Spouse* ☐*Other*
Policy Holder Name(if different than patient's name):		

☐ **Blue Cross/Blue Shield of RI***(enter 3 letters and 10 numbers)* ☐ **UnitedHealthcare** ID #_____

__ __ __ __ __ __ __ __ __ __ __ __ __ Group#_____

☐ **Other** *(Tufts or Neighborhood Health Plan of RI)* _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. ☐**Y** ☐**N** Have you ever had a serious reaction to intranasal influenza vaccine (FluMist) in the past? (If you answer yes, you may not receive this vaccine)
2. ☐**Y** ☐**N** Have you ever had a serious reaction to injectable influenza vaccine in the past? (If you answer yes, you may not receive this vaccine)
3. ☐**Y** ☐**N** Do you have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs? (If you answer yes, you may not receive FluMist)
4. ☐**Y** ☐**N** Do you have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood? (If you answer yes, you may not receive FluMist)
5. ☐**Y** ☐**N** Do you receive aspirin therapy or aspirin-containing therapy? (If you answer yes, you may not receive FluMist)
6. ☐**Y** ☐**N** Are you pregnant or could you become pregnant within the next month? (If you answer yes, you may not receive FluMist)
7. ☐**Y** ☐**N** Do you live with or expect to have close contact with a person whose immune system is severely compromised and who must be in a protective isolation (such as in a hospital room with reverse airflow)? (If you answer yes, you may not receive FluMist)
8. ☐**Y** ☐**N** Have you received seasonal FluMist in the past 4 weeks? (If you answer yes, you may not receive FluMist)
9. ☐**Y** ☐**N** Have you ever had an allergic reaction to Thimerosol?

DO NOT WRITE BELOW THIS LINE UNTIL YOU APPEAR FOR YOUR FLU SHOT

VACCINE ADMINISTRATION RECORD & NOTICE OF PRIVACY PRACTICE

I have read or have had explained to me the information provided about influenza and influenza vaccine. I have had an opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and request that the vaccine be given to me or to the person named above for whom I am authorized to sign. I hereby release *The Wellness Company* from any and all liability associated with the administration and potential side effects of the vaccine.

This record is evidence and/or documentation that you have received the flu vaccine and it will be filed with *The Wellness Company*. They will record what vaccine was given, when the vaccine was given, where the vaccine was given, the name of the company that made the vaccine, the vaccine's lot number, and the name and title of the person who gave the vaccine.

I certify that I have received and/or reviewed a Notice of Privacy Practice provided by *The Wellness Company*.

CLIENT SIGNATURE: X_____ DATE: _____

TO BE COMPLETED BY HEALTHCARE PROFESSIONAL

Do you have a fever today? ☐Y ☐N Are you currently taking antibiotics? ☐Y ☐N

Clinic/Site Location: _____ VIS Date: **10/02/2009**

Immunization Site: **Nostrils** **R** **L** **Deltoid** Vaccine Maker: _____ Vaccine Lot #_____

Signature/Title of Vaccine Administrator: _____ Date:_____